

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3574
CERTIFICATE OF DEATH

03540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIO-VISTA NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL</u> <u>Rudolph</u> <u>BARNES</u>		4. DATE OF DEATH Month Day Year <u>MAR</u> <u>4</u> <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 15 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TIME KEEPER (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATE Road</u>	
11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES JOSEPH BARNES</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA PLUMMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>MISS ELIZABETH BARNES ST MICHAELS MD</u>	
17. INFORMANT Address <u>MISS ELIZABETH BARNES ST MICHAELS MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic cardiovascular d.</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-4</u> , 19 <u>53</u> , to <u>3-4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-4</u> , 19 <u>59</u> , and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guy M Reeker Jr</u> M.D. <u>St Michaels md</u>		DATE SIGNED <u>3-6-59</u>	
PHYSICIAN'S NAME (Type) <u>Guy M Reeker Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 7-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St Michaels md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hamberton Harrison</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>	
ADDRESS <u>St Michaels</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
SIGNED AND SWORN TO before me this		day of		month of		year		at	
my hand and the seal of my office		this		day of		month of		year	
NOTARY PUBLIC		DECEASED		FAMILY		WITNESSES		MINISTER OF THE GOSPEL	
SIGNED AND SWORN TO before me this		day of		month of		year		at	
my hand and the seal of my office		this		day of		month of		year	
NOTARY PUBLIC		DECEASED		FAMILY		WITNESSES		MINISTER OF THE GOSPEL	

1

3546
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>240. Norman St</u>	
3. NAME OF DECEASED (Type or print) <u>E. Virginia Baynard</u>		4. DATE OF DEATH <u>March 26</u> 19 <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11 1913</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician Own Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Baynard</u>		14. MOTHER'S MAIDEN NAME <u>Katie Elliott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-656274</u>	
17. INFORMANT <u>John J. Baynard</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of ovary.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>27 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1958</u> , to <u>3 1959</u> , that I last saw the deceased alive on <u>3/11/59</u> , 19 <u>59</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED			
ACTUAL SIGNATURE <u>J. Tyler Baker</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. T. BAKER</u> <u>EASTON MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 27, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

5240

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE AVE.		RETIRED		HEART DISEASE		NATURAL		JAN 25 1945		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		HIGH SCHOOL		METHODIST		MARRIED		MARRIED	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAN 25 1945		J. H. HARRIS		JAMES H. HARRIS		MARY J. HARRIS		J. H. HARRIS		J. H. HARRIS	

5240

5240

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10/10/01 BY 60322 UCBAW/STP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3547

CERTIFICATE OF DEATH

03542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale - RFD 09X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>NEAR ELDORADO</u>	
3. NAME OF DECEASED (Type or print) <u>TERRIE</u> First <u>LYNN</u> Middle <u>Baby</u> Last <u>Biskach</u>		4. DATE OF DEATH <u>March</u> Month <u>19</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1959</u> yrs. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank C. Biskach</u>		14. MOTHER'S MAIDEN NAME <u>Patricia Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Patricia Biskach (mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>763.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Anoxia</u> (c) <u>Hemorrhagic Pneumonitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>16 hrs</u> <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-19</u> , 19 <u>59</u> , to <u>3-19</u> , 19 <u>59</u> that I last saw the deceased alive on <u>3-19</u> , 19 <u>59</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Biskach</u> M.D.		ADDRESS (Street, city or town, state) <u>205 Earle Ave Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN E. BISKACH</u>		DATE SIGNED <u>3-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eldorado Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Eldorado Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson</u> ADDRESS <u>and Son Federalburg, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

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MAILED TO STATE DEPARTMENT OF HEALTH-BIRMINGHAM 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03543

3548

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> 092-2	
c. LENGTH OF STAY in 1b <u>4 days</u>		d. STREET ADDRESS <u>R.F.D #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY Frances</u> First <u>X</u> Middle <u>BRIAN</u> Last		4. DATE OF DEATH <u>March</u> Month <u>19</u> Day <u>1959</u> Year	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22 1915</u> 43 yrs.
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry M. Slickerson</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-01-2344</u>	
17. INFORMANT <u>Carlton Brian - husband - same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Idiopathic dilatation and hypertrophy of the heart</u> DUE TO (c) <u>3 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-16</u> , 1959, to <u>3-19</u> , 1959, that I last saw the deceased alive on <u>3-19</u> , 1959, and that death occurred at <u>10</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.		<u>Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 22, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OLD SCHOOL BAPTIST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR LAUREL, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frayntom Son, Federalburg Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

3552

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		Jan 15, 1950		10:30 AM		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of birth		18. Sex		19. Age		20. Signature of informant	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21201		Jan 1, 1905		Female		45		[Signature]	
21. Name of funeral home		22. Address		23. City		24. State		25. Zip		26. Date of funeral		27. Time of funeral		28. Place of funeral		29. Signature of funeral home		30. Signature of registrar	
ABC Funeral Home		456 Elm St		Baltimore		Maryland		21201		Jan 20, 1950		11:00 AM		Church		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3549

CERTIFICATE OF DEATH

Reg. Dist. No.

03544

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>EASTON Memorial Hospital</u>		1. d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Marcellus</u> First <u>BROWN</u> Middle Last		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1904</u>
9. AGE (In years last birth day) <u>54</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marcellus Brown</u>		14. MOTHER'S MAIDEN NAME <u>Annie Dyce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alice Brown, wife</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage with intra-ventricular and subarachnoid extension</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>59</u> , to <u>3-11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>59</u> , and that death occurred at <u>1:40</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u> DATE SIGNED <u>3-13-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown</u>		22d. LOCATION (City, town, or county) (State) <u>Healdsboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. [illegible]</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles J. [illegible]</u>	

3575

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>	
c. LENGTH OF STAY IN 1b <u>50 YRS.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>ST. MICHAELS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BETHINE</u> <u>HELMOND</u> <u>BUCK</u>		4. DATE OF DEATH Month Day Year <u>MAR.</u> <u>3</u> <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 29, 1883</u>
9. AGE (In years last birthday) <u>75 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES A. CRISCI</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>Edward R. Buck, West Falmouth, Mass.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> (c) <u>Cornary Artery, Heart Dis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 YR.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleurisy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Wroth</u> M.D.		ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u>		DATE SIGNED <u>3-5-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CLIVET CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ST. MICHAELS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Givell</u>		ADDRESS <u>ST. MICHAELS MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 2-12-59 3-30-59 at

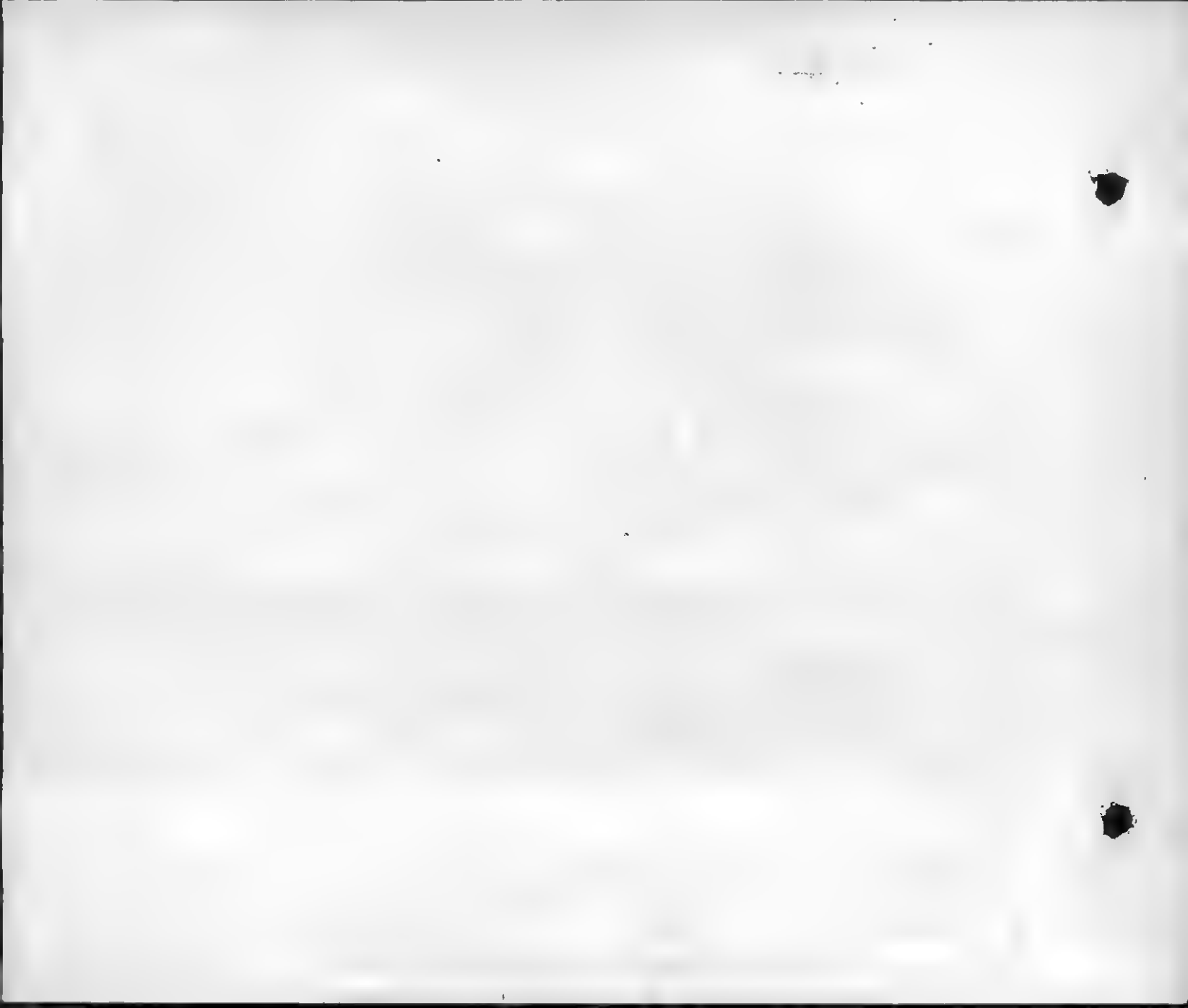
CERTIFICATE OF DEATH

03546

Reg. Dist. No.

3576

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>		c. LENGTH OF STAY IN lb <u>26 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>P.</u> Last <u>Cassidy</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1879</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal & Oil Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William A. Cassidy</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Beaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>M. J. P. Cassidy</u>		Address <u>Easton, Md. P.O.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic renal & hepatic disease, obesity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April</u> , 19 <u>46</u> , to <u>21 Mar</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>21 Mar</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton Maryland</u> DATE SIGNED <u>23 Mar 59</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Mar 23, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>King's Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanna</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03547

Reg. Dist. No.

3550

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>R.F.D. #2 Box 111</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Ronald Dean</u>		4. DATE OF DEATH Month Day Year <u>March 12 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 22 1956</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Neal Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute septicaemic meningitis</u> <u>082.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. C. H. Schmidt</u> M.D.		DATE SIGNED <u>13 March 1959</u>	
PHYSICIAN'S NAME (Type) <u>F. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/14/15</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Roswell</u> ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3551

CERTIFICATE OF DEATH

04776
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 - Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Benjamin</u> Last <u>Friend</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 25, 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>OKLAHOMA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES FRIEND</u>				14. MOTHER'S MAIDEN NAME <u>DORA QUICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>111-17-1503</u>		17. INFORMANT <u>MRS. ETHEL FRIEND - EASTON, MD.</u> Address <u>"LIFTON"</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1957, to <u>March 26</u> , 1959, that I last saw the deceased alive on <u>March 26</u> , 1959, and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald A. Bartley</u> M.D.				ADDRESS (Street, city or town, state) <u>9 N. Hanson St. Easton, Md.</u>		DATE SIGNED <u>3-26-59</u>	
PHYSICIAN'S NAME (Type) <u>Donald A. Bartley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>03/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OXFORD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>OXFORD MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Langston</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford P. Henry</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3577

CERTIFICATE OF DEATH

03541

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels Rural</u>		c. LENGTH OF STAY IN TB <u>1 yr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels - rural</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>A.</u> Last <u>Gamble</u>			4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6 - 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Congressman</u>		11. BIRTHPLACE (State or foreign country) <u>South Dakota</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Robert S. Gamble</u>			14. MOTHER'S MAIDEN NAME <u>Carrie O. Abernethy</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, for dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-3651A</u>	17. INFORMANT Address <u>Mrs Ralph Gamble St Michaels Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>157x</u> DUE TO <u>cachexia severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>adenocarcinoma pancreas</u> DUE TO <u>adenocarcinoma pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>with generalized metastases - lung - abd</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wks</u> <u>1 mo.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-1-59</u> to <u>3-4-59</u> , that I last saw the deceased alive on <u>3-4-59</u> , and that death occurred at <u>2:50</u> A. M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ray M Reeser Jr</u> M.D. ADDRESS <u>St Michaels Md</u> DATE SIGNED <u>3-4-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 6, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rt Deposit Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u> ADDRESS <u>108 S. Hagerstown St. Washn, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2, 4, 11, 3240 4-1-59 et

CERTIFICATE OF DEATH

03550

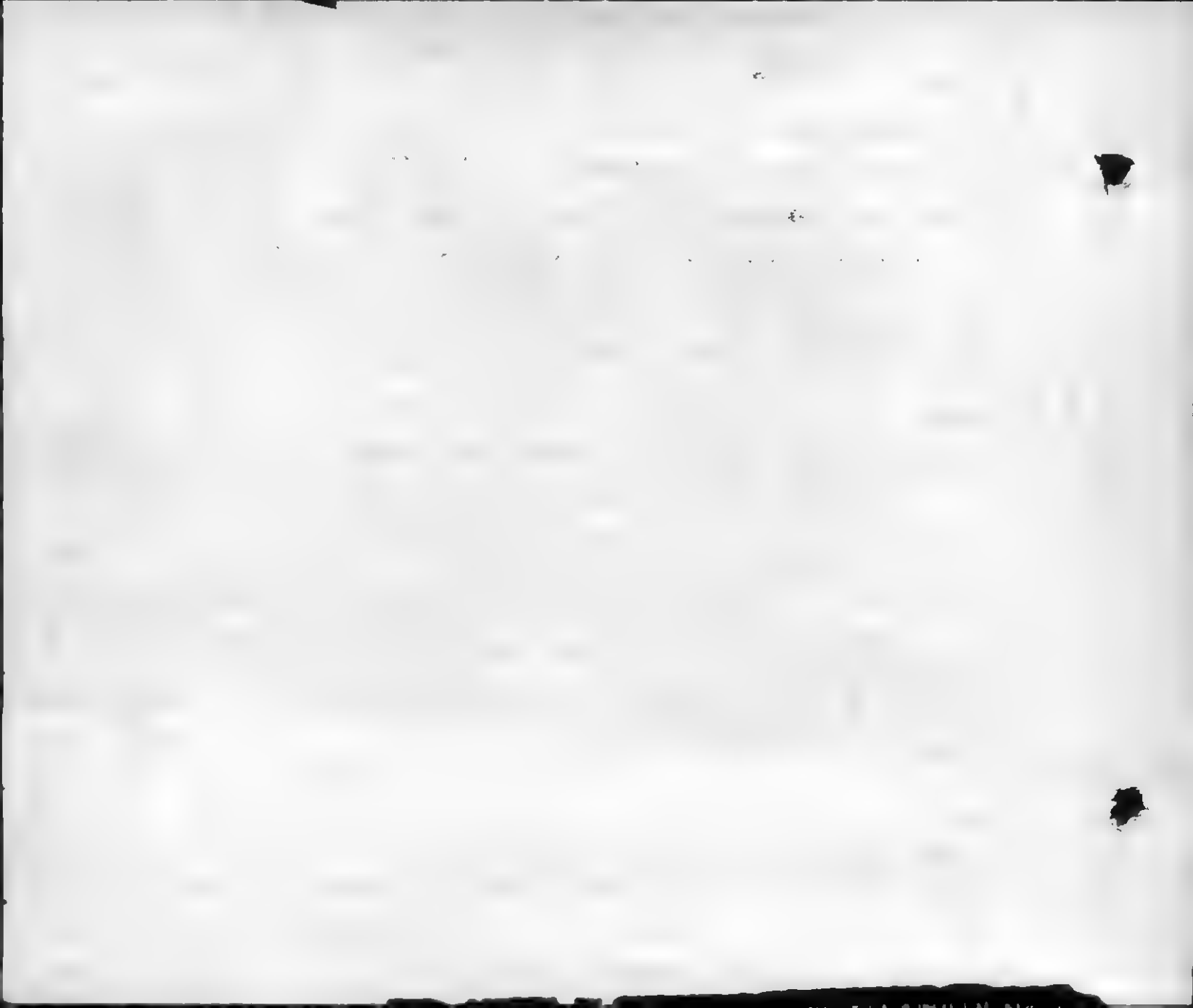
3552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Sackett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Sackett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>Salschies Street</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET ALICE GAREY</u>		4. DATE OF DEATH <u>March 24 1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 16, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Can Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Garey</u>		14. MOTHER'S MAIDEN NAME <u>M. Elizabeth Plummer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or both) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John H. Garey</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/24</u> , 19 <u>59</u> , to <u>3/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. J. Egbertson</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Md.</u>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <u>3/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 30 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Egbertson</u>		24a. REC'D BY REGISTRAR <u>Mar 30 '59</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>Robert H. Egbertson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

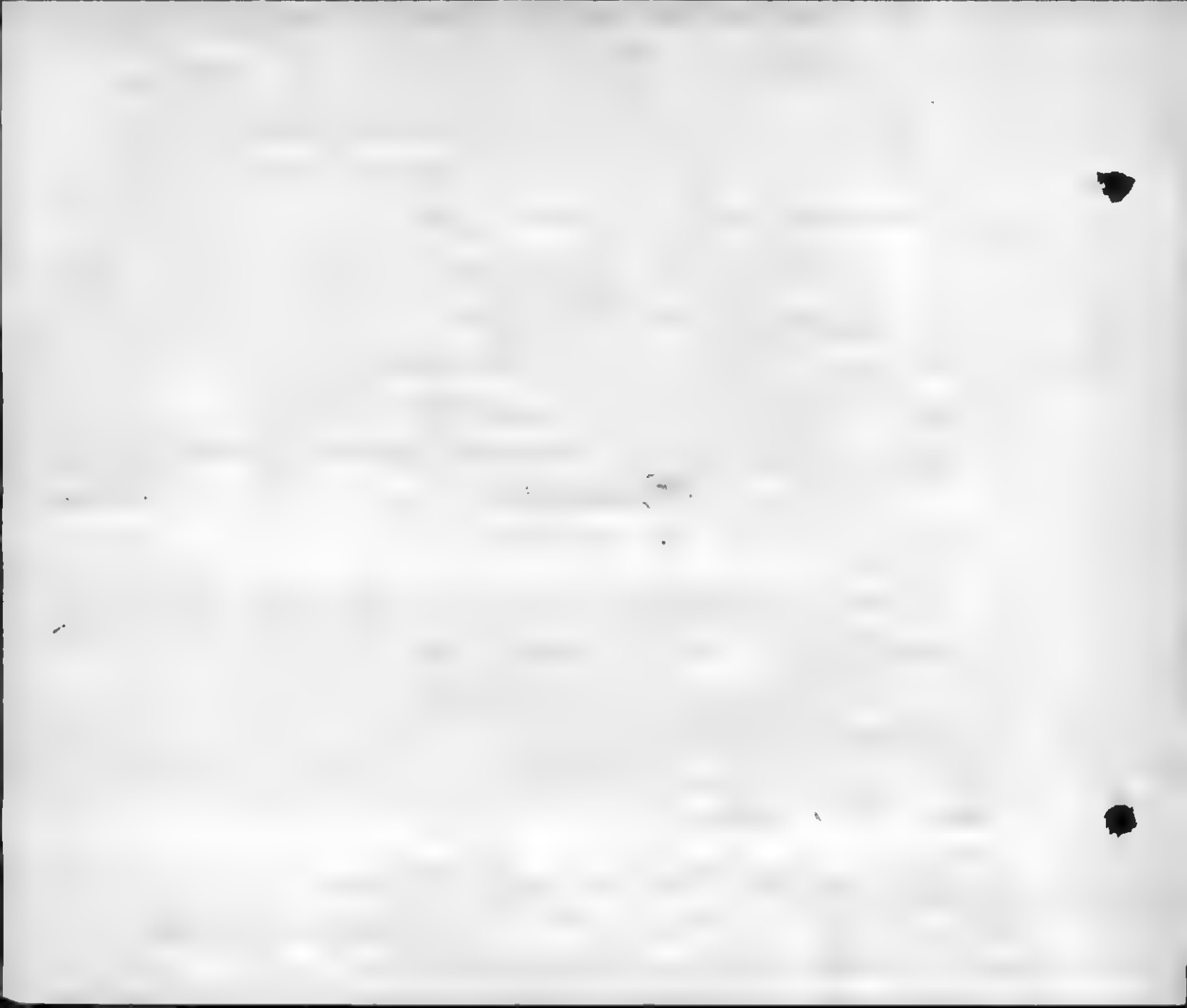
3553

CERTIFICATE OF DEATH

03551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>11-115</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> R Middle <u>R</u> Last <u>Gray</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 23, 1879</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Robert Henry Gray</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1-2-3-4-5-6-7-8-9-0</u>		17. INFORMANT <u>Resident of the family</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1st CVD</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/25/59</u> to <u>3/1/59</u> , that I last saw the deceased alive on <u>3/1/59</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P F Cox</u>				DATE SIGNED <u>3/2/59</u>			
PHYSICIAN'S NAME (Type) <u>P F Cox M.D.</u>				ADDRESS (Street, city or town, state) <u>Easton Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. ...</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03552

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN 1b 15 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admits on) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely d. STREET ADDRESS e. I, RESIDENT ON A FAPAT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carroll First Middle Last 4. DATE OF DEATH March 9 1959 Month Day Year		5. SEX Male 6. COLOR OR RACE Col 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan. 14 1898 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> AGE (in years last birthday) 67 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 10b. KIND OF BUSINESS OR INDUSTRY (If in place of foreign country) md 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Preston Griffin 14. MOTHER'S MAIDEN NAME Nerrietta Sparks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 16. SOCIAL SECURITY NO 17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple 7 fractures Head Spines DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Internal Hemorrhage - Shock DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY (a) OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident 20c. TIME OF INJURY Month, Day, Year 3-7 1959 Hour o. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) Rural Ridgely Caroline Md		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Dawson D. George EXAMINER'S NAME (Type) DAWSON D. George		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-9-59	
22a. RURAL CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Mar 12, 1959 22c. NAME OF CEMETERY OR CREMATORY Spring Grove 22d. LOCATION (City, town, or county) (State) Denton, Md		23. FUNERAL DIRECTOR'S SIGNATURE J. Virgil McCondon 24a. REC'D BY REGISTRAR Arthur S. House DATE MAR 13 '59 24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in (b) and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



3578

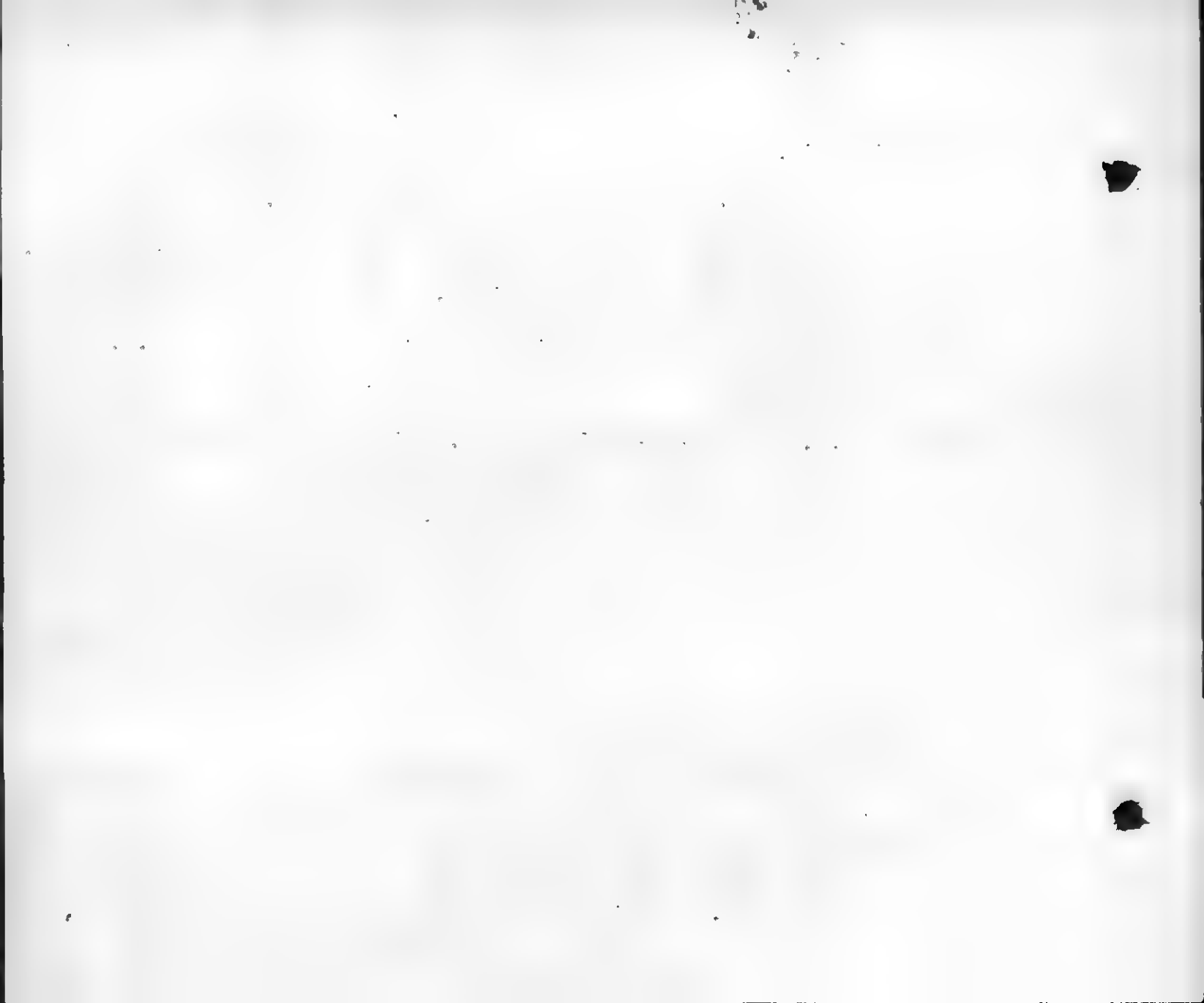
CERTIFICATE OF DEATH

03553

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived If inst. in Res. before adm. on) a. STATE Id. b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman's Island		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman's Island	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Avalon P.O.		e. STREET ADDRESS Avalon, P.O.	
3. NAME OF DECEASED (Type or print) First Frank Middle H Last Grill		4. DATE OF DEATH Month March Day 20 Year 1959	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 9, 1893
9 AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom Maker		10b. KIND OF BUSINESS OR INDUSTRY Blind Work Shop	
11. BIRTHPLACE (State or foreign country) Providence, R.I.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Grill		14. MOTHER'S MAIDEN NAME Pauline Wiegand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 217-07-7011	
17. INFORMANT Anna C. Grill		Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 22X DUE TO Alcohol's depression of reflexes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from March 19, 1959 to March 20, 1959 that I last saw the deceased alive on March 19, 1959 and that death occurred at 6:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Tilghman's Island, Talbot Co., Md. DATE SIGNED ACTUAL SIGNATURE GUY M REESER Sr M.D. PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3-23-59 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery 22d. LOCATION (City, town, or county) (State) E. North Ave. Balto., Md. 23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Zeller ADDRESS 9015 CONKLING ST. BALTO., MD 24a. REC'D BY REGISTRAR MAR 23 59 24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03554

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Trappe		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Trappe	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 164 Rt. 2		e. STREET ADDRESS Box 164 Rt. 2	
3. NAME OF DECEASED (Type or print) Gregory Oneal Hensley		4. DATE OF DEATH Month 3 Day 22 Year 19 59	
5. SEX M	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Carroll Hensley		14. MOTHER'S MAIDEN NAME Mary L. Canpher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1-10-100000-100000	
17. INFORMANT Arthur S. Hensley		Address Box 164 Rt. 2, Talbot Co., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sickle cell anemia 272.6 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis Whately		DATE SIGNED 3-23-59	
EXAMINER'S NAME (Type) W. E. K. T. V.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/59	
22c. NAME OF CEMETERY OR CREMATORY Trappe Cem.		22d. LOCATION (City, town, or county) Trappe, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md.		24a. REC'D BY REGISTRAR DATE MAR 24 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hensley	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

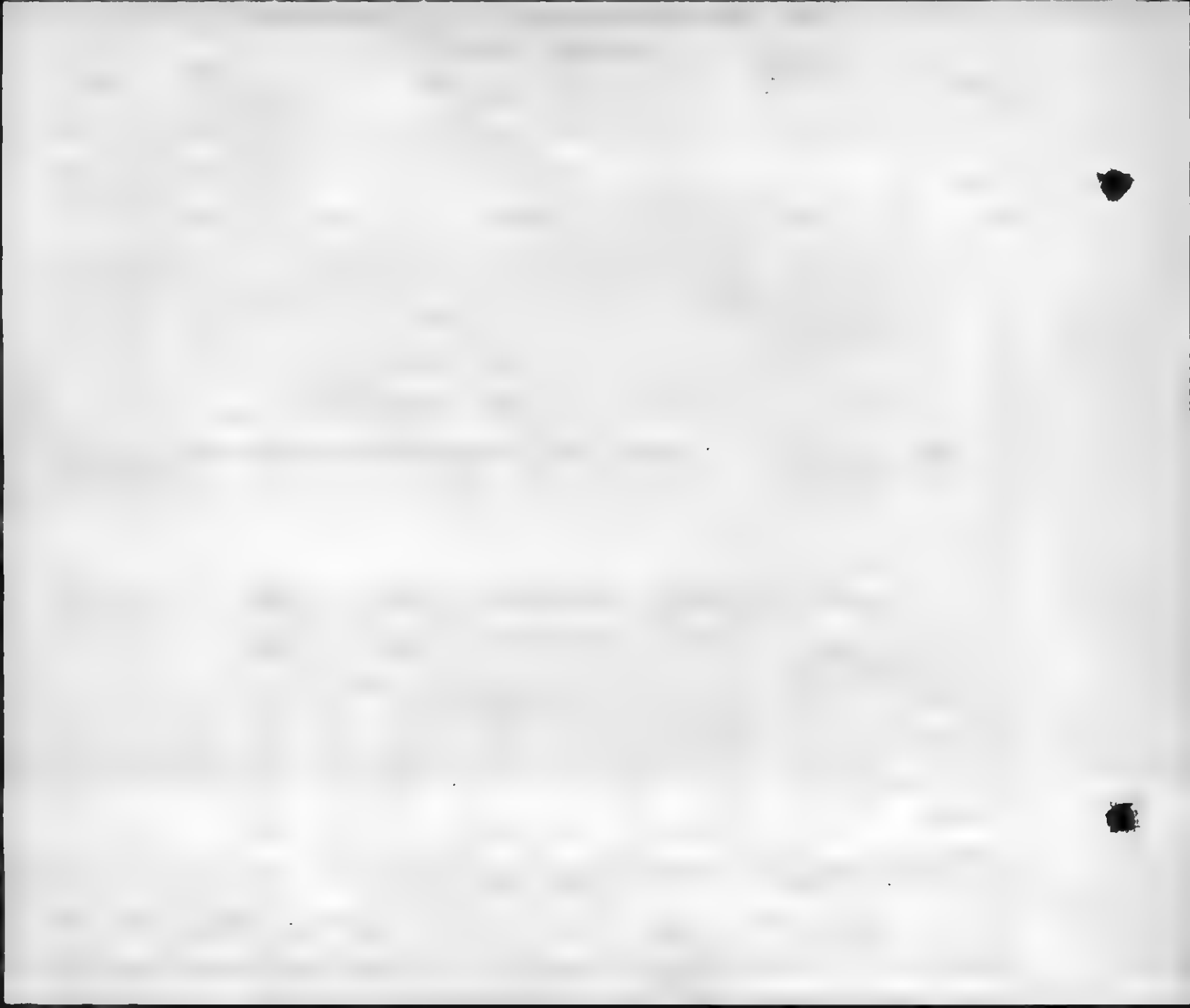
3555

CERTIFICATE OF DEATH

Reg. Dist. No.

03555

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>17 x</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oakley KERSEY Higdon</u>		4. DATE OF DEATH Month Day Year <u>3 - 15 - 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1900</u>
9a. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>18</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Higdon</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Clayton Clifton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-03-5061</u>	
17. INFORMANT <u>Mr. William F. Higdon</u> Address <u>Queenstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Infection</u> <u>4:01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior Coronary Thrombosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:54</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmitt</u> M.D.		DATE SIGNED <u>21 5-1357 72-57 5-13-59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>March 17 - 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Schmitt</u> ADDRESS <u>13201 Bn. Centerville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3556

CERTIFICATE OF DEATH

Reg. Dist. No.

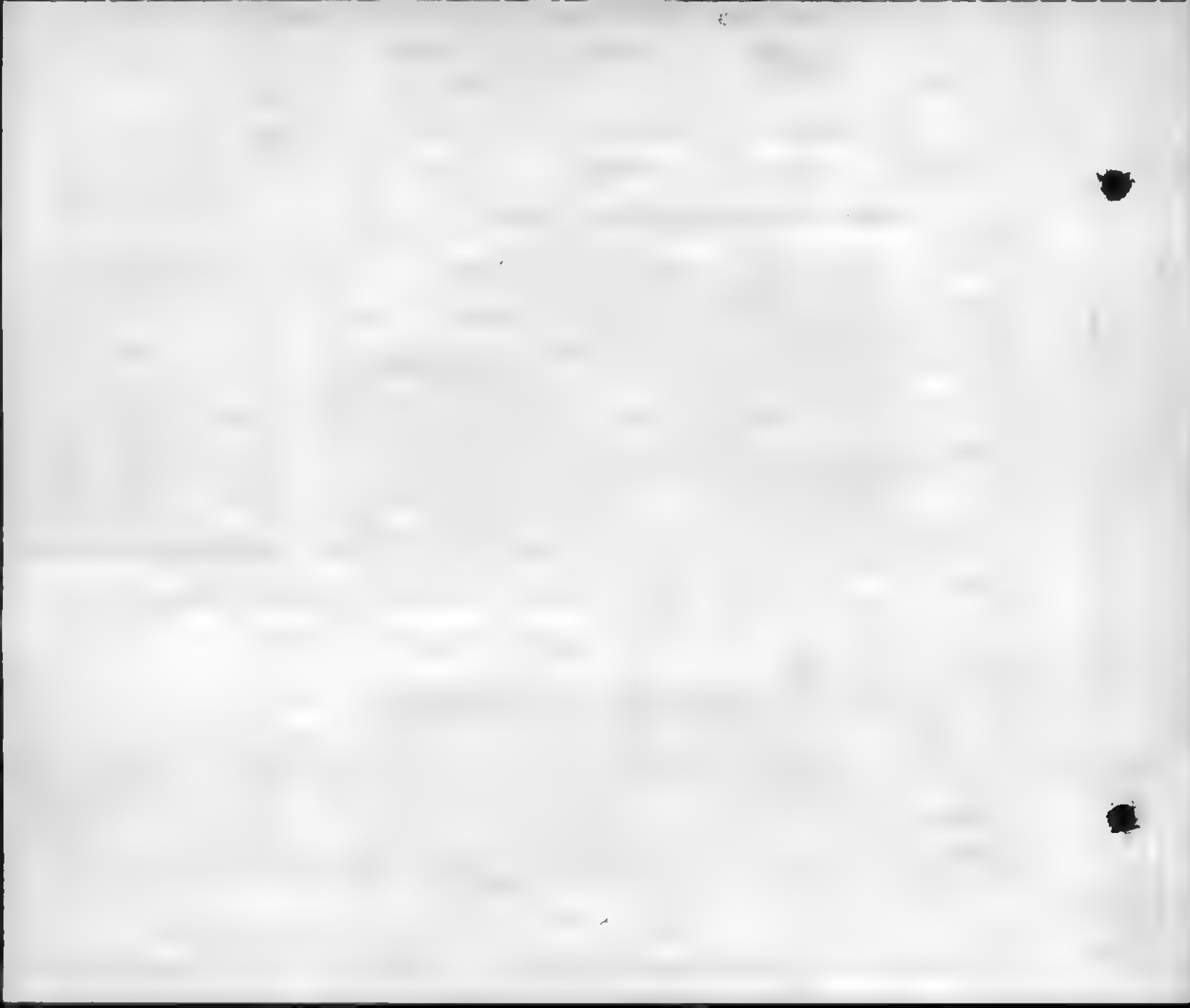
03556

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William D. Jackson</u>		4. DATE OF DEATH Month Day Year <u>March 30 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3 1964</u>
9. AGE (In years last birthday) <u>95</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET BRIDGE TENDER</u>	
11. BIRTHPLACE (State or foreign country) <u>11-1-1964</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Noah Jackson</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH CUMMINGS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Miss BERTHA JACKSON, ST. MICHAEL, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic cardiovascular</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/24/1</u> , 19 <u>59</u> , to <u>3/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-30</u> , 19 <u>59</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3-30-59</u>			
ACTUAL SIGNATURE <u>Thos. M. Reese</u> M.D.		PHYSICIAN'S NAME (Type) <u>Thos. M. Reese</u> M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michael's Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert T. Harrison</u> ADDRESS <u>St. Michael's</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3557

CERTIFICATE OF DEATH

03557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Easton Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Lewis</u> Middle <u>B</u> Last <u>12</u>		4. DATE OF DEATH <u>March 8</u> Month <u>12</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1886</u> yrs. <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Cheezum</u>		14. MOTHER'S MAIDEN NAME <u>Isabel Kirby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MR. ALFRED E. LEWIS</u>		Address <u>EASTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LLX</u> DUE TO <u>Apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis & embolism</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1945</u> to <u>1959</u> , that I last saw the deceased alive on <u>1959</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Al Cox</u> M.D.			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carroll</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u> DATE	
ADDRESS <u>EASTON, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3558

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03558

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellevue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First John Middle T. Last McCormick		4. DATE OF DEATH Month March Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. McCormick		14. MOTHER'S MAIDEN NAME Label Mc Cormick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:55 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 219 S. Washington St. Easton 16 Maryland DATE SIGNED 3 Mar 59			
ACTUAL SIGNATURE E.C.H. Schmidt M.D.		PHYSICIAN'S NAME (Type) E.C.H. Schmidt	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 12 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

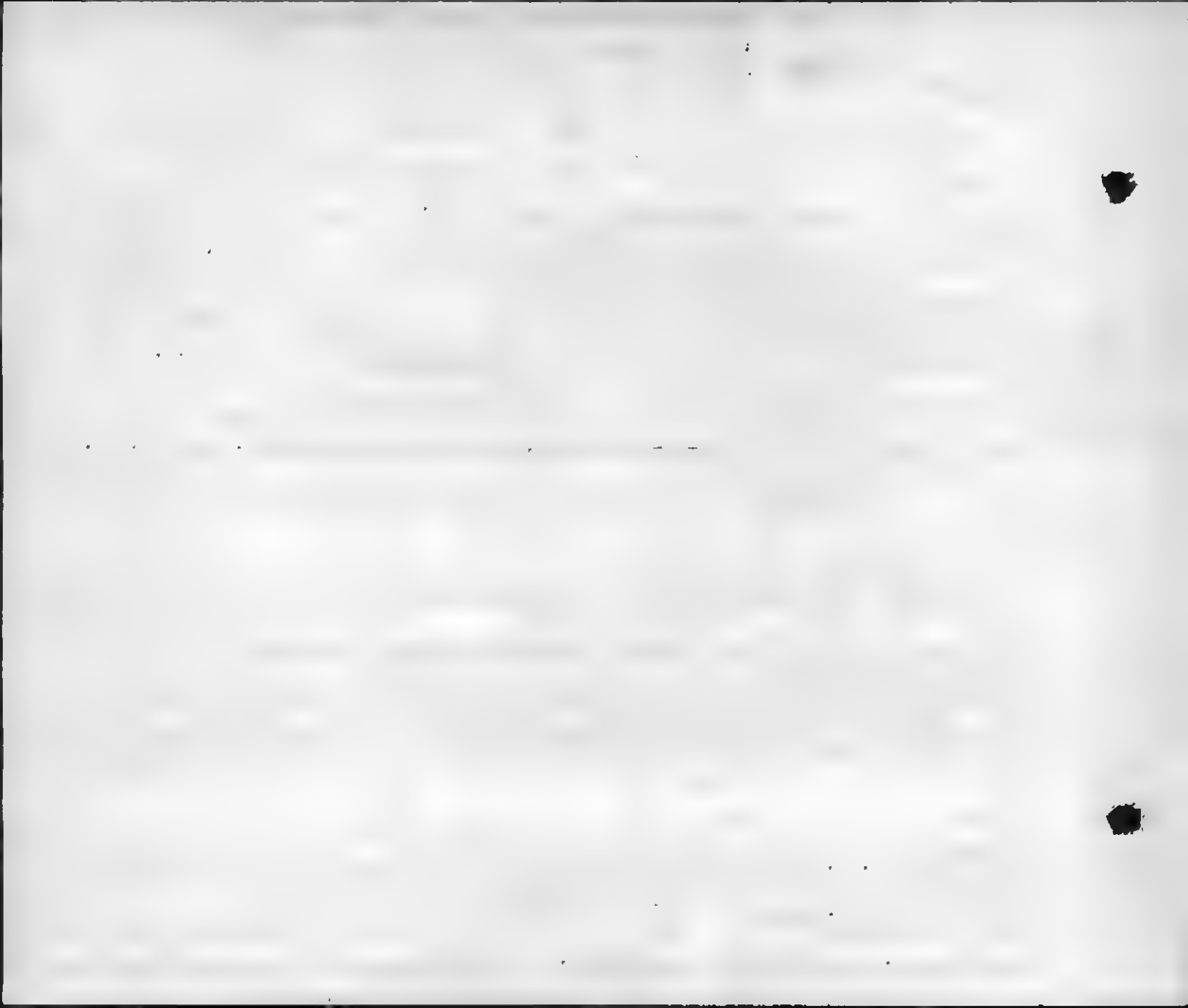


3559
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) Dover St		d. STREET ADDRESS Dover St.	
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last MERRICK		4. DATE OF DEATH Month March Day 30 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1924
9. AGE (In years last birthday) 34 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Griffin Merrick		14. MOTHER'S MAIDEN NAME Neva LeCompte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-16-7494	
17. INFORMANT Mrs. Neva Merrick		Address Dover St. Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 15 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/29/1959 to 3/29/1959 , that I last saw the deceased alive on 3/29/1959 , and that death occurred at 11:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. P. Evans Cox Easton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 1, 1959	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	24a. REC'D BY REGISTRAR DATE APR 6 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

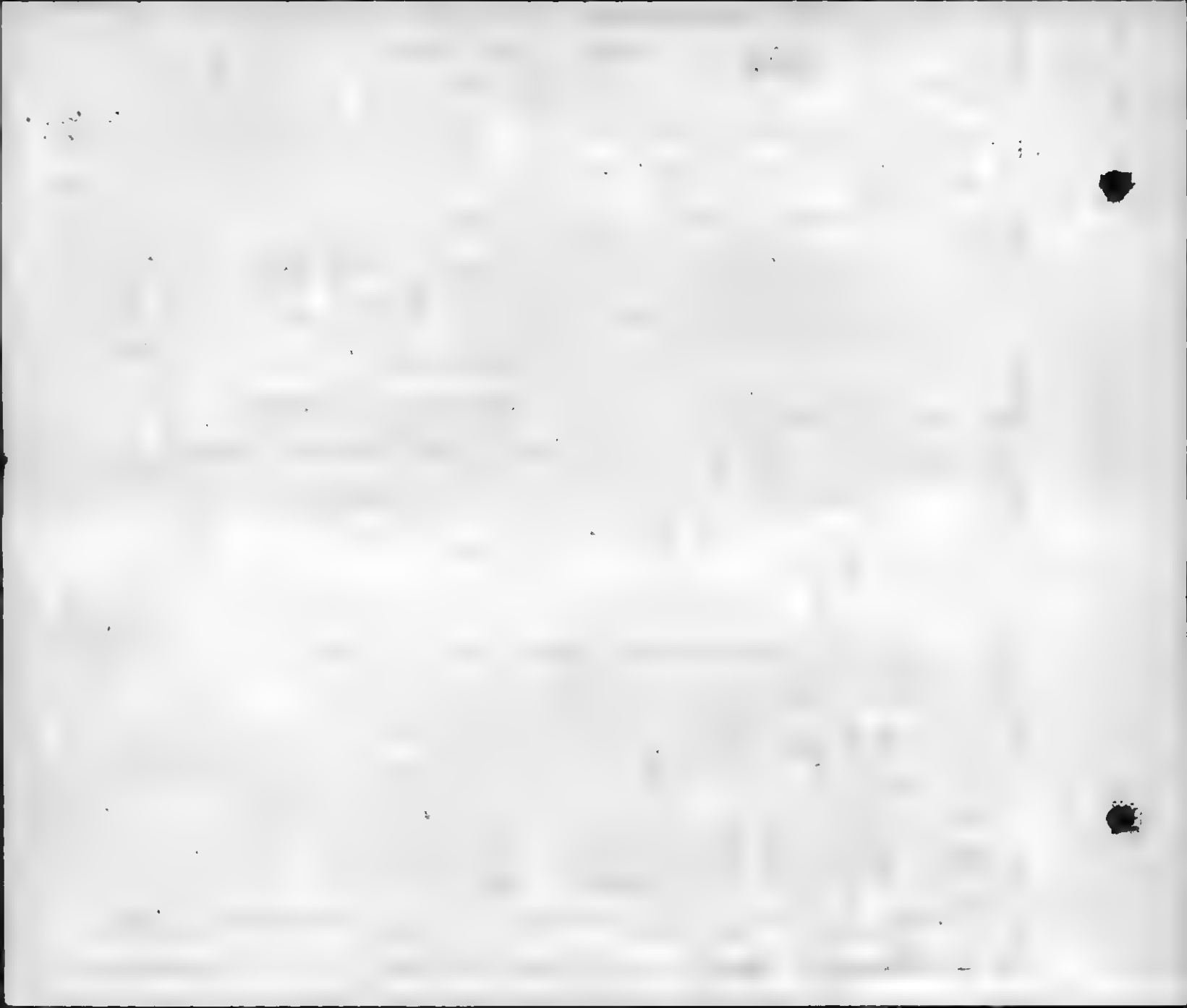
03560

3560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hospital</u>				d. STREET ADDRESS <u>11</u>			
3. NAME OF DECEASED (Type or print) First <u>H</u> Middle <u>T</u> Last <u>11</u>				4. DATE OF DEATH Month <u>14</u> Day <u>14</u> Year <u>19</u>			
5. SEX <u>11</u>	6. COLOR OR RACE <u>11</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-11</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert</u>				14. MOTHER'S MAIDEN NAME <u>11</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>		17. INFORMANT <u>Mrs. Hazel Missis - wife</u> Address <u>11</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Meas. 10 U. S. medical</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ad. 10 for trans. medical report</u> DUE TO <u>11</u> (c) <u>11</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>11</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>11</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>11</u>	
20f. (City or town) <u>11</u>				20g. (County) <u>11</u>		20h. (State) <u>11</u>	
21. I certify that I attended the deceased from <u>11</u> , 19 <u>59</u> , to <u>11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11</u> , and that death occurred at <u>11</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>11</u> M.D.				ADDRESS (Street, city or town, state) <u>2195 Washington St 15 Md 59</u>			
PHYSICIAN'S NAME (Type) <u>E C H. Sotiriou</u>				DATE SIGNED <u>Factor 16 Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEMT.</u>		22d. LOCATION (City, town, or county) (State) <u>HILLSBORO, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>11</u> ADDRESS <u>11</u>				24a. REC'D BY REGISTRAR <u>DATE APR 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	



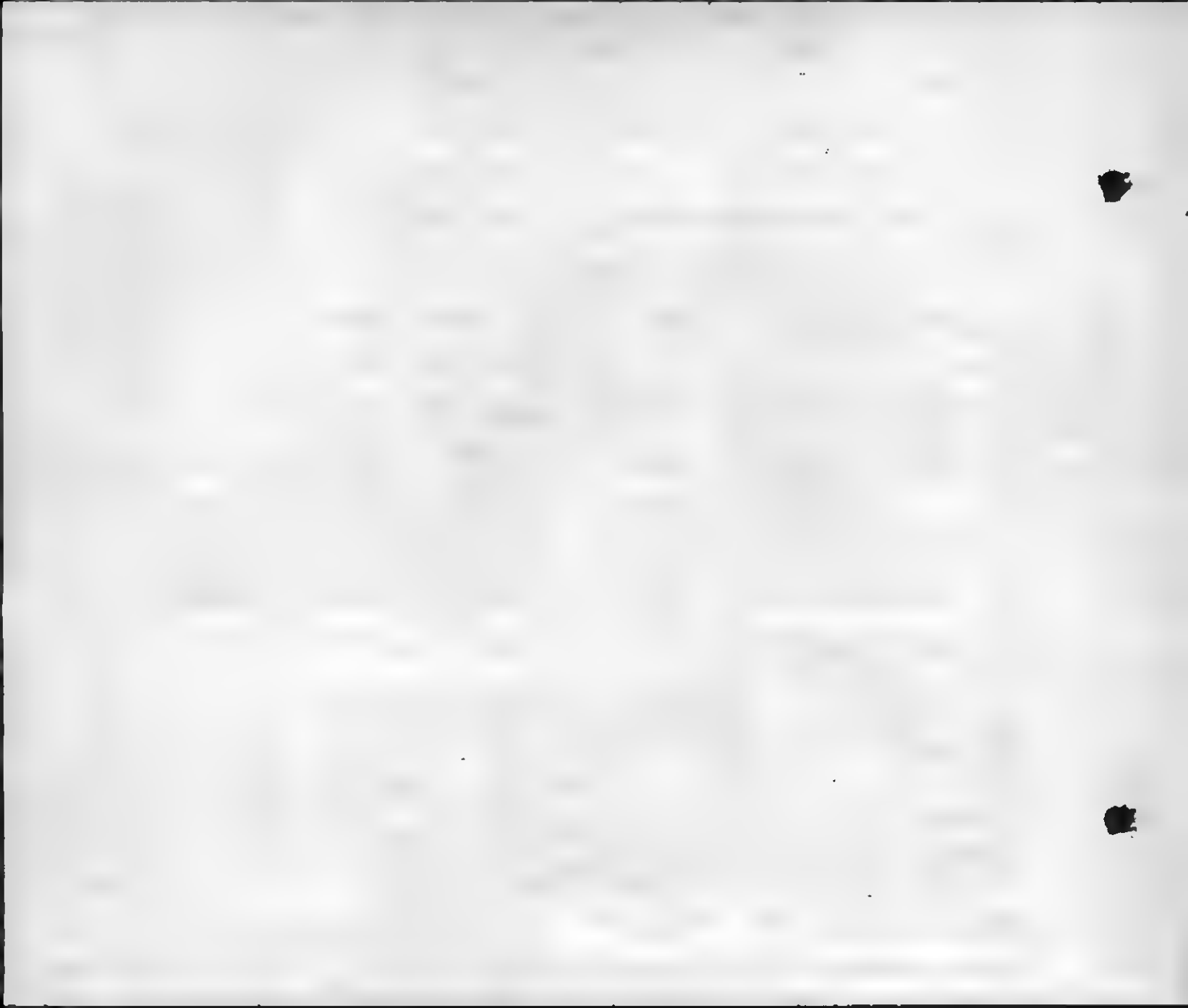
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3561 Item 1 Filed 3-16-59 at
CERTIFICATE OF DEATH

Reg. Dist. No.

03561

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>MORRIS ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Harmon</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27 1884</u>			
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Robert Patrick Mills</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Robbins</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Mary Mills, wife - same</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arterial Accidents</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intermittent Cardiac arrhythmias</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>12/1 1958</u> to <u>3/6 1959</u> , that I last saw the deceased alive on <u>3/6 1959</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u> </u>									
ACTUAL SIGNATURE <u> </u> M.D.									
PHYSICIAN'S NAME (Type) <u> </u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Mar 1 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u> </u>		22d. LOCATION (City, town, or county) (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



3580

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution (Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>				c. LENGTH OF STAY in 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak, Md</u>			
3. NAME OF DECEASED (Type or print) First <u>Virgie</u> Middle <u>Moore</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/30/1887</u>	
9. AGE (In years last birthday) yrs. <u>70 1/2</u>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charley Handy</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Handy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Anna Jerry Royal Oak, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Hypertensive Cardiovascular Dis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>2 days</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour <u>a. m.</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) <u>19</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb 11</u> , 19 <u>59</u> to <u>Feb 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>59</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>K. Bruce Smith</u>				ADDRESS (Street, city or town, state) <u>Box 487 St Michaels, Md</u>			
DATE SIGNED <u>March 6 1959</u>							
PHYSICIAN'S NAME (Type) <u>James B. Daniels</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Royal Oak Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Royal Oak Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Daniels</u>				ADDRESS <u>Cotter, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

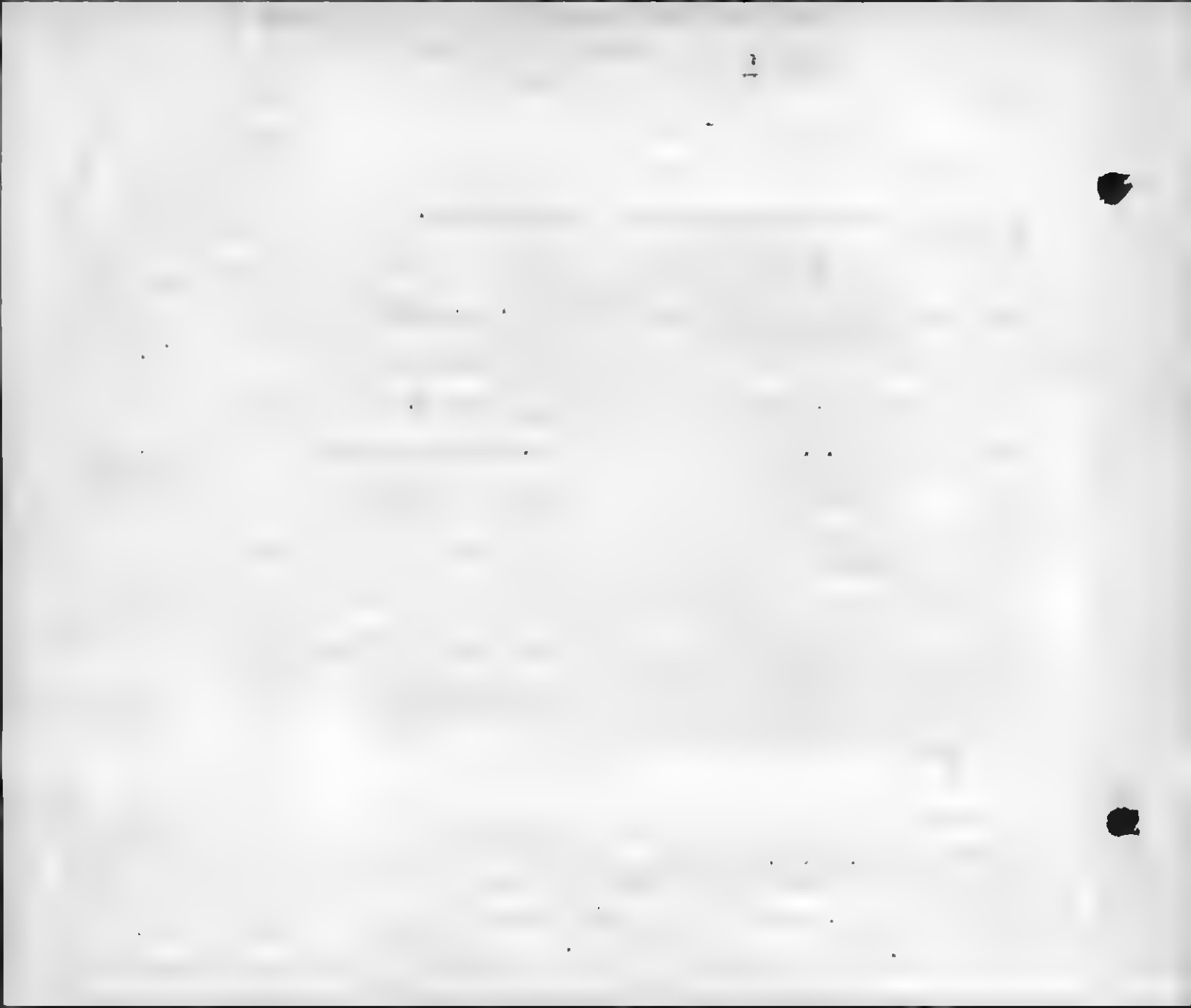
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Main St.	
3. NAME OF DECEASED (Type or print) First WALTER Middle FRANCIS Last MOORE		4. DATE OF DEATH Month 3 Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1893
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) civil engineer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter R. Moore		14. MOTHER'S MAIDEN NAME Mary E. Johns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Catherine Valliant		Address Bellevue, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension Heart Disease DUE TO Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour none 19 57 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1957 to 3-26 , 19 57 , that I last saw the deceased alive on 3-17 , 19 57 , and that death occurred at 8 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Maryland DATE SIGNED 3/27/57			
ACTUAL SIGNATURE William L. Winters		M.D. Barton	
PHYSICIAN'S NAME (Type) Dr. Wm. L. Winters		Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE APR 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by our files.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03564

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	c. LENGTH OF STAY IN 1b <u>4 hrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monticelli Hospital</u>		d. STREET ADDRESS <u>NEAR MT. PLEASANT</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17, 1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>	9. AGE (In years last birthday) <u>79</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT GREEN</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN JANE (LAST NAME UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS RUTH SHAPIR</u>		Address <u>PHILADELPHIA 19, PA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Cause undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. Wehly</u>		DATE SIGNED <u>3-11-59</u>	
EXAMINER'S NAME (Type) <u>WEHLY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MARCH 16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>NEAR PRESTON, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR <u>MAR 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



3582

CERTIFICATE OF DEATH

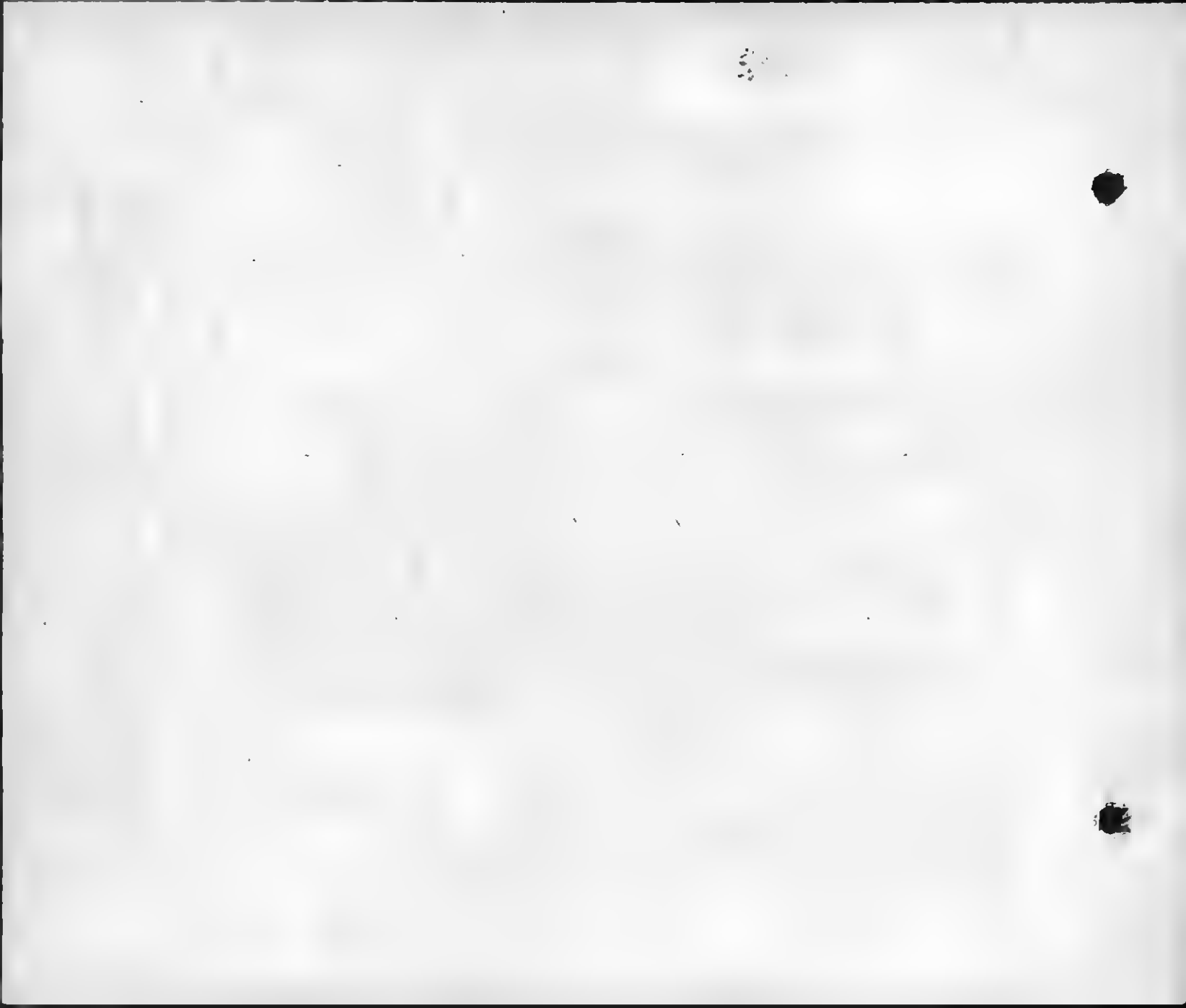
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS E. CHESTNUT	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE C. NEWMAN SR.		4. DATE OF DEATH Month MAR Day 19 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 1, 1885
9. AGE (in years last birthday) 73 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISHERMAN		10b. KIND OF BUSINESS OR INDUSTRY COMMERCIAL	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES NEWMAN		14. MOTHER'S MAIDEN NAME LULU WILLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT George C. Newman Jr.		Address St. Michaels Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure - 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cachexia severe-generalized DUE TO (c) adenocarcinoma stomach		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) with multiple metastases - M - Liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6-1-1958 to 3-19-1959 , that I last saw the deceased alive on 3-19-1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.		
ACTUAL SIGNATURE Thymon Beeson M.D. St Michaels Md		DATE SIGNED 3-20-59
PHYSICIAN'S NAME (Type) Thymon Beeson		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 3-21-59	22c. NAME OF CEMETERY OR CREMATORY Heavitt Cemetery
22d. LOCATION (City, town, or county) (State) Heavitt Md		
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Harrison		24. REGISTRAR'S SIGNATURE Arthur E. House
25. REC'D BY REGISTRAR DATE MAR 23 '59		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3583

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural St. Michaels		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MAURICE EVEREST NEWMAN		4. DATE OF DEATH Month Day Year Mar. 10, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1874
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William B. Newnam		14. MOTHER'S MAIDEN NAME Edith Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-34-7421	
17. INFORMANT Mrs. Maurice Newnam, Sr.		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic cardiac and (c) cerebrovascular d		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia - chronic, cachexia generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-3 1956 to 3-10 1959 , that I last saw the deceased alive on 3-10 1959 , and that death occurred on 11-5 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Guy M. Reeser, Jr.		ADDRESS (Street, city or town, state) DATE SIGNED 3-13-59	
PHYSICIAN'S NAME (Type) Dr. Guy M. Reeser, Jr.		St. Michaels, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 14, 1959	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DAMAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3584

CERTIFICATE OF DEATH

Reg. Dist. No.

03517

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St. Michaels</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Peter's Nursing Home</u>		d. STREET ADDRESS <u>Denton</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Almira Frances Crane</u>		4. DATE OF DEATH Month Day Year <u>March 12 1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Selected Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cover Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Gray Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Francis Almira Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXXX-XX-XXXX</u>	
17. INFORMANT <u>E. L. Crane</u>		Address <u>Denton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral hemorrhage</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>atherosclerotic cardiocerebrovas. d.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 wks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-22</u> <u>1959</u> , to <u>3-12</u> <u>1959</u> , that I last saw the deceased alive on <u>3-12</u> <u>1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry M. Reeser Jr.</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>St. Michaels Md</u> <u>3-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Harry M. Reeser Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>March 15, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Cox</u>		24a. RECEIVED BY REGISTRAR DATE <u>MAR 16 1959</u>	
ADDRESS <u>Denton Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

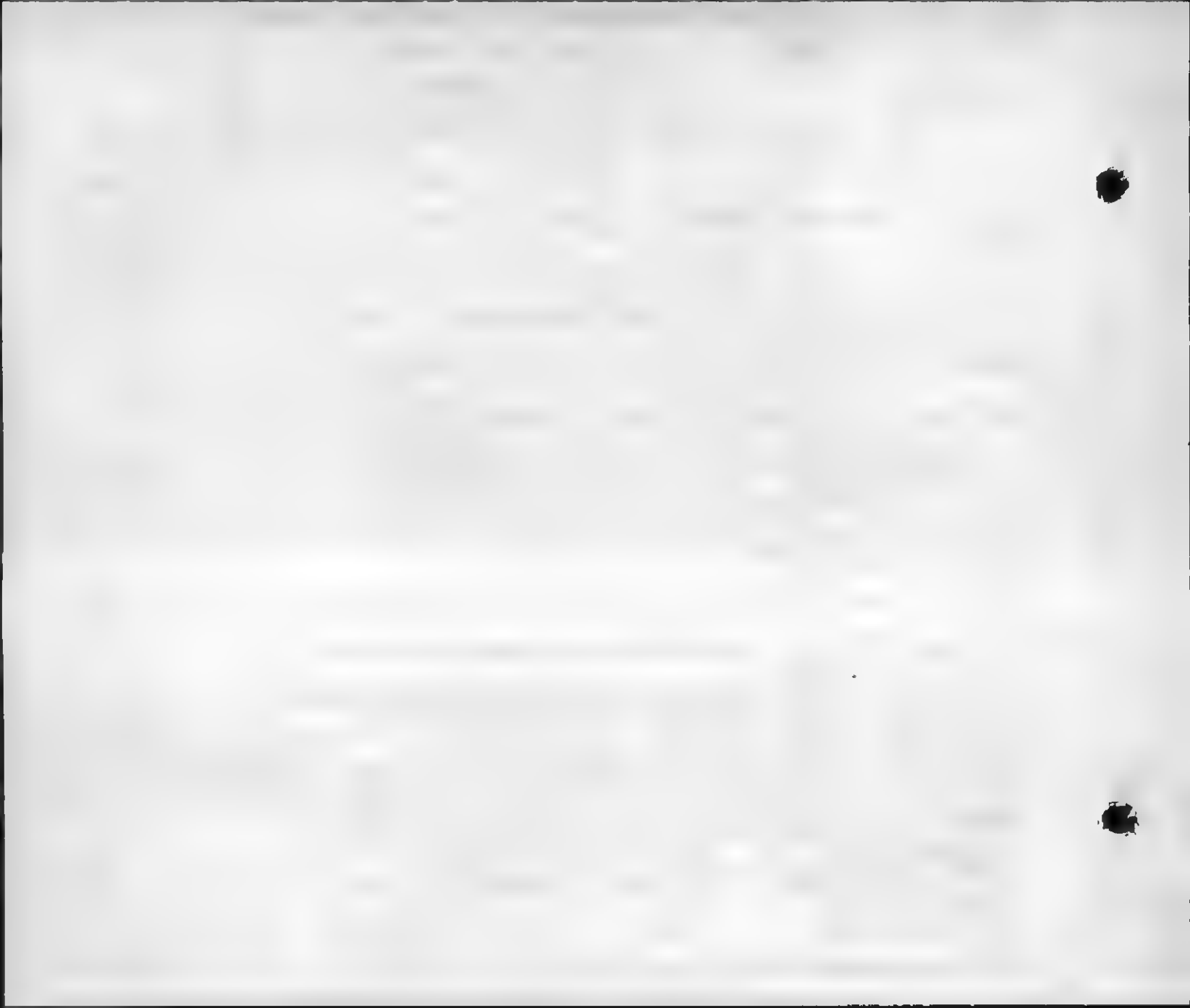
3563

CERTIFICATE OF DEATH

Reg. Dist. No.

118758

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
c. LENGTH OF STAY IN 1b <u>9 days</u>				d. STREET ADDRESS <u>77 -</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Postel</u> Last <u>Postel</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14 1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager engineering</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>None</u>	
13. FATHER'S NAME <u>Henry Postel</u>				14. MOTHER'S MAIDEN NAME <u>Elenetina Reiner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>086-01-4826</u>		17. INFORMANT Address <u>Theodore Postel 77 -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death Senilitis</u> <u>550.1</u> DUE TO <u>Ruptured aortic dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Perkins</u> 19 <u>59</u> to <u>March 6</u> 19 <u>59</u> , that I last saw the deceased alive on <u>March 5</u> 19 <u>59</u> and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Baltimore, Md.</u> DATE SIGNED <u>12 Mar 59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				LOCATION (City, town, or county) (State) <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>St. John's, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. E. B. ...</u> ADDRESS <u>...</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

3564 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03569

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grosmont</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Dayherty Porty</u> First Middle Last		4. DATE OF DEATH <u>March 29 1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 16 1917</u>
9. AGE (In years last birthday) <u>41</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Optical Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Percy Price</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-07-1755</u>	
17. INFORMANT <u>Fannie Price</u> Address <u>Waverly, N.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>442 X</u> DUE TO <u>Hypertensive nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Schmidt</u> M.D.		DATE SIGNED <u>2195 W. Washington St. 7/2/59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 2 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Buttrick of Buttrick, Centerville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3565

CERTIFICATE OF DEATH

Reg. Dist. No.

03570

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton. - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ezekiel</u> Middle <u>Reed</u> Last <u>Reed</u>				4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 19, 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>A J Reed</u>				14. MOTHER'S MAIDEN NAME <u>Martha Hastings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Mrs HARRY M. EVANS, Jr., Easton, Md.</u>				Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4343</u> DUE TO <u>Heimorrhagic peri-arthritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>pm</u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. <u>2195 Lexington St. Easton, Md.</u>				DATE SIGNED <u>29 March 1959</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				ADDRESS <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/31/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hampton Harrison</u> ADDRESS <u>111 Michael</u>				24b. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



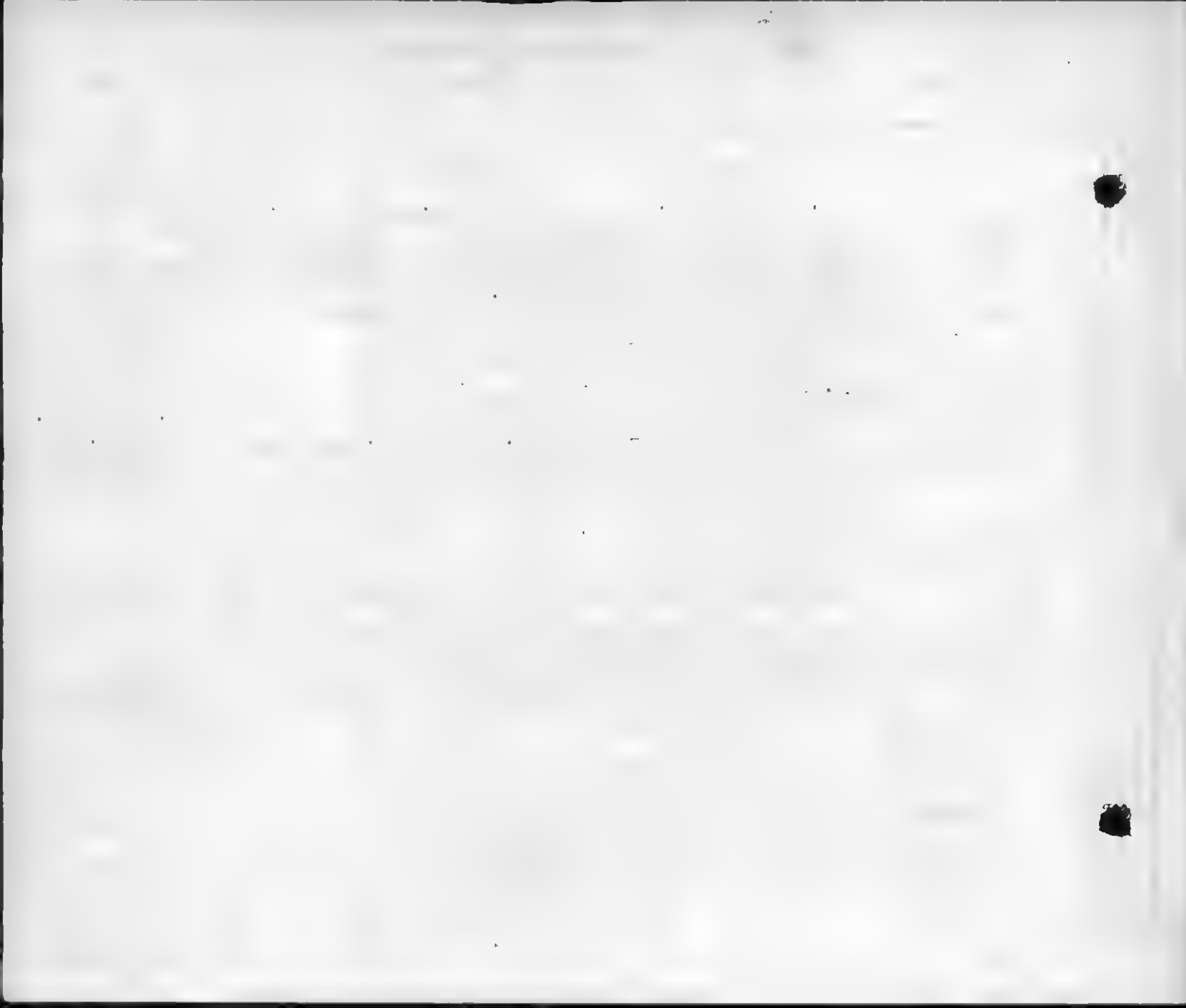
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3566
CERTIFICATE OF DEATH

03571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN TB 78yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 N. Locust St.				e. STREET ADDRESS 119 N. Locust St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Gertrude Flynn Roe				4. DATE OF DEATH Month March Day 24 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1880	
				9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist				10b. KIND OF BUSINESS OR INDUSTRY Florist-owner		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles H. Flynn				14. MOTHER'S MAIDEN NAME Luraina Kirby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no none				16. SOCIAL SECURITY NO. 214034-6038			
17. INFORMANT Mrs. Alfred G. McKewen, Easton, Md.				Address 119 N. Locust St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma toxis DUE TO Carcinoma of Right Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) EASTON		(County) (State)	
21. I certify that I attended the deceased from 9/29, 1952 to 3/23, 1959 , that I last saw the deceased alive on 3/23, 1959 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) EASTON DATE SIGNED 3/24/59 ACTUAL SIGNATURE Shepard Krech, Jr. M.D. PHYSICIAN'S NAME (Type) SHEPARD KRECH, JR. MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/58		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR DATE APR 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3567
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN TB 24 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS RIDGELEY	
3. NAME OF DECEASED (Type or print) First Anna Middle Adelle Last Santury		4. DATE OF DEATH Month 2 Day 76 Year 19	
5. SEX F	6. COLOR OR RACE 	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13
9. AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ABRAHAM WRIGHT		14. MOTHER'S MAIDEN NAME AMANDA HICKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Long standing high blood pressure		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Have a. p. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from 1/13/59 , 19 59 , to 2/1/59 , 19 59 , that I last saw the deceased alive on 1/13/59 , 19 59 , and that death occurred at 3:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. Smith		ADDRESS (Street, city or town, state) DATE SIGNED 2/1/59	
PHYSICIAN'S NAME (Type) E. C. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 10, 1959	
22c. NAME OF CEMETERY OR CREMATORY Denton		22d. LOCATION (City, town, or county) (State) Denton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. V. ... ADDRESS Denton		24a. REC'D BY REGISTRAR MAR 13 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3568

CERTIFICATE OF DEATH

03573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <u>Delaware</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Castle Delaware</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>124 Stalhove Wilmington Mar</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>SHARP</u> Last <u>SHARP</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 1887</u>	9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. Luke Wooters</u>				14. MOTHER'S MAIDEN NAME <u>MARtha Kirkman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>XXX</u>		17. INFORMANT <u>Raymond Sharp</u> Address <u>New Castle Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombosis, left middle cerebral artery</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the sigmoid colon</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-24</u> , 19 <u>59</u> , to <u>3-31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-31</u> , 19 <u>59</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>3-31-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.				DATE SIGNED <u>3-31-59</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>				Easton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 4, 1959</u>		<u>Spring Hill Cem.</u>		<u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
						DATE <u>APR 6 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



3569

CERTIFICATE OF DEATH

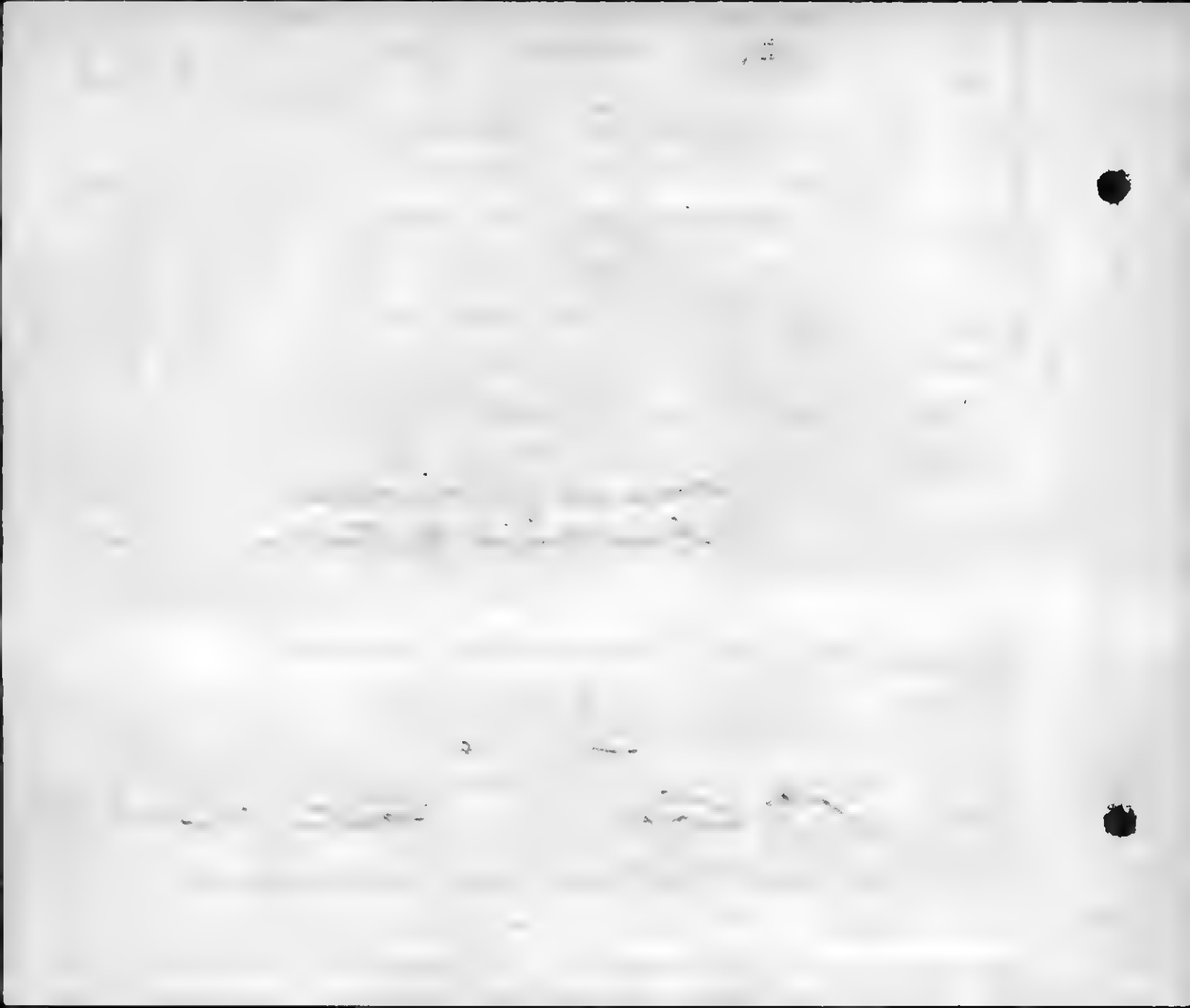
Reg. Dist. No.

03574

1. PLACE OF DEATH a. COUNTY <u>A/bot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Bloomfield Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Thomas</u> Last <u>Swan</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 6, 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Swan</u>				14. MOTHER'S MAIDEN NAME <u>Laura Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-947-19</u>		17. INFORMANT <u>Mrs. Anna Swan</u> Address <u>Easton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chondrosarcoma Metastasis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>3/22</u> , 19 <u>58</u> , to <u>3/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>59</u> , and that death occurred at <u>4:59 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Coy.</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>3/24/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 24, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bellman Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. Williams</u>				ADDRESS <u>Easton</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 24 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara S. Kenna</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3570

CERTIFICATE OF DEATH

04795
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>141401</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sherwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1100 N. 2nd St. Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCK</u> <u>WALLACE</u>		4. DATE OF DEATH Month Day Year <u>3</u> <u>22</u> <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 27, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>Md. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES WALLACE</u>		14. MOTHER'S MAIDEN NAME <u>MARY VAN DYKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>6 KN</u>	
17. INFORMANT <u>MR. THOMAS WALLACE, SHERWOOD, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO <u>Carcinomatous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Cervix uteri</u> DUE TO (c) <u>Carcinoma of Cervix uteri</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>From</u> <u>147</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>17</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 12</u> , 19 <u>59</u> , to <u>22 March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12</u> , 19 <u>59</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Wroth</u> M.D.		ADDRESS (Street, city or town, state) <u>457 St. Michaels, Md</u>	
DATE SIGNED <u>3-23-59</u>			
PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SHERWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SHERWOOD MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. ...</u>		24a. REC'D BY REGISTRAR <u>...</u>	
24b. REGISTRAR'S SIGNATURE <u>...</u>		DATE <u>APR 14 '59</u>	



3571

CERTIFICATE OF DEATH

03575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Easton</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Webb</u> Last <u>Webb</u>		4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Chase</u>		14. MOTHER'S MAIDEN NAME <u>Louise Chase</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Elsie Ketter</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Parenchymatous Nephritis</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>55</u> , to <u>March 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 22</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Haymond G. Holt</u> M D			
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/25/59</u>	<u>Richards Cem</u>	<u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3572

CERTIFICATE OF DEATH

Reg. Dist. No.

03576

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		d. STREET ADDRESS <u>058-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vannie</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Preacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Bledsoe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robenia Frame</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infect, right cerebrum</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 19</u> to <u>March 6, 19</u> , that I last saw the deceased alive on <u>March 1, 19</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>719 S. West 11th St. - 70159</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		DATE SIGNED <u>March 16, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel R. Schmitt</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Catherine L. Hays</u>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BELLINGHAM, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3573

CERTIFICATE OF DEATH

03577

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1123 S. Hanson St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Herman</u> Middle <u>Wolf</u> Last				4. DATE OF DEATH <u>March 24</u> 19 <u>59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 19, 1896</u> 63 yrs.	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DENTAL TECH.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ERNEST WOLF</u>				14. MOTHER'S MAIDEN NAME <u>UNKN OWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>467 01 1091</u>		17. INFORMANT <u>JOS. WOLF</u> <u>EASTON MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arterio-sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-27-</u> 19 <u>58</u> , to <u>3-24-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Mar. 24</u> 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D.				ADDRESS (Street, city or town, state) <u>9 N. HANSON ST. EASTON, MD.</u>		DATE SIGNED <u>3-25-59</u>	
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 25, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEN. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Newman</u> ADDRESS <u>Easton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

